Kathy Bryan – Oversight Committee on MHDDSAS Presentation
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MH reform was started with the idea that MH and SA, but particularly MH needed reforming. DD had a strong presence in the Division, had a single portal referral system and was actively engaged in providing person-centered planning services. It's hard not to feel like the "baby was thrown out with the bath water" Single portal is gone, our waiting list is gone, our presence in the Division has been reduced.

However, good things have happened also. Best practice has been legislated as the required service. Legislators are certainly driving the process more, there are real expectations that NC will deinstitutionalize and existing agencies are moving towards community-based services.

DD has had to scramble to maintain a presence within the Division. There has also been little focus on how best practice is defined for DD. There has been a lack of expertise within the Division at the decision-making level (certainly more so with the former director.) This is especially problematic since people who have DD do not have an illness. They can't get well nor can they go into remission. People with DD are not sick, do not need treatment and will not recover. They can all live, work and play in the community if they have proper supports.

What has happened and continues to happen is that DD service providers are expected to develop services that fit into the provision of and reporting mode for the medically-based models of Mental Health and Substance Abuse. This is not only inefficient, but affects the quality of the services we can deliver. For example, we have to report in 15 minute increments of time, and make daily notes for waiver services. The unnecessary paper work and dollars required for administrative duties would be much better spent in direct service dollars.

Community capacity is out there for DD services. We believe there are excellent providers who are either providing only community-based services or are converting to community-based. However, it is absolutely critical that these agencies be funded at a level where they can function. This includes being paid on time. Many service providers are being paid more than 90 days late. This is truly a disaster for these agencies, both large and small. When the director of a service provider has to spend time worrying about and finding the dollars for the next payroll, they are not focused on service provision. It certainly does not allow time or energy for creativity and thus reduces consumer choice. It also affects the development of new services or at the very least the stability and "staying power" of new services.

When the State changed the way they paid LME's (the switch from providing the dollars at the beginning of the month to making the LME's bill first, then wait on payment from the State) there was an immediate cash-flow crisis. Service providers who had not had to wait more than two weeks or a month were immediately thrown into a 45 day waiting period and as money has tightened up many of us are having to wait longer and longer.

We also need to support those service providers who are trying to convert to community-based services. They need some bridge funding, because it is impossible to convert without running a dual system for a period of time. This is just more expensive and should be recognized as such and adequately funded.

There is also the issue of different interpretation of rules, service definitions, quality standards, documentation requirements, billing requirements and contracts. Each LME has a different version under which they operate, and if a service provider works across LMEs, then this lack of standardization creates unnecessary administrative costs. Every time rules are changed or different standards/requirements are put into place, each service provider has to retrain staff and absorb all the attending costs. Sometimes, it feels like the consumer is the last and least important thing we have to deal with, and that is totally unacceptable.

What can the State and LMEs do to help improve community supports? For service providers the answers are fairly clear. Of course, we can never let the opportunity to ask for adequate funding pass us by, so more funding; but we also need reimbursement in a timely fashion. We need a waiting list so that we can plan for the future. For those providers still offering facility-based services, we may need some technical assistance in moving into the community (and to be fair, the Division is helping sponsor the Network of Organizational Change to do just that for community rehabilitation programs) and we need the bridge money to make it happen. We need standardization across LMEs. We need to ensure a uniform software system that has statewide protocols for authorizations, billing and payment of services. And we need a mechanism to ensure that the funding that you allocate for specific services is actually being distributed for those services.

Thank you for the opportunity to address you directly and also thank you for your dedication to the consumers that we serve. It is abundantly clear, that your heart is with consumers.